TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ULTIMATE PAIN SOLUTIONS

Respondent Name
EMPLOYERS PREFERRED INS CO

MFDR Tracking Number
M4-17-2926-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
JUNE 5, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Ultimate Pain Solutions believe that the claims listed below were underpaid and unpaid Employers Preferred Insurance Company did not pay the (MAR) Maximum Allowable Reimbursement value."

Amount in Dispute: $39,450.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider is a non-CARF accredited facility and the correct reimbursement is $100.00 per hour. Each date of service should be paid at $800.00 for 8 hours of pain management billed. Please see the attached EOR reflecting the additional payment due. CPT 90791 for date of service 10/16/16 has also been paid."

Position Summary Submitted by: Conduent

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 13, 2016	CPT Code 90791(X3)	$3,000.00	$0.00
November 21, 2016 through January 30, 2017	Chronic Pain Management Program CPT Code 97799-CP (Total of 145 Hours)	$36,450.00	$0.00
TOTAL		$39,450.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.

3. 28 Texas Administrative Code §134.230, effective July 17, 2016 sets out the reimbursement guidelines for chronic pain management programs.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1001-Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - W3-Additional payment made on appeal/reconsideration.
   - 600-Allowance based on maximum number of units allowed per fee schedule guidelines and/or service code description.
   - 309-The charge for this procedure exceeds the fee schedule allowance.

Issues

1. Is the requestor entitled to additional reimbursement for CPT code 90791 rendered on October 13, 2016?
2. Is the requestor entitled to additional reimbursement for the chronic pain management program rendered on November 21, 2016 through January 30, 2017?

Finding

1. The requestor is seeking reimbursement of $3,000.00 for CPT code 90791 rendered on October 13, 2016. The respondent states that "CPT 90791 for date of service 10/16/16 has also been paid." To determine if additional reimbursement is due the division refers to 28 Texas Administrative Code §134.203.

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code §134.203 (b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   CPT code 90791 is defined as "Psychiatric diagnostic evaluation."

   A review of the submitted billing finds that the requestor billed for three units of code 90791. Per the CPT code descriptor this is not a timed procedure code. Based on the code descriptor one unit is recommended for reimbursement.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2016 DWC conversion factor for this service 56.82.

   The Medicare Conversion Factor is 35.8043.

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 77042, which is located in Houston, Texas; therefore the Medicare carrier locality is "Houston, Texas".

The Medicare participating amount for code 90791 is $134.47.

Using the above formula, the Division finds the MAR is $213.40. The respondent paid $640.20. As a result, additional reimbursement is not recommended.

2. The requestor is seeking additional reimbursement of $36,450.00 for a chronic pain management program rendered to the injured worker from November 21, 2016 through January 30, 3017.

   To determine if additional reimbursement is due the division refers to 28 Texas Administrative Code §134.230.

   28 Texas Administrative Code §134.230(1) states "Accreditation by the CARF is recommended, but not required.
   (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the maximum allowable reimbursement (MAR).
   (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."
   The requestor billed 97799-CP; therefore, the disputed program is non-CARF accredited and reimbursement shall be 80% of the MAR.

   28 Texas Administrative Code §134.230 (5) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.
   (A) Program shall be billed and reimbursed using CPT code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited programs shall add "CA" as a second modifier.
   (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The requestor billed for 145 hours of non-CARF accredited chronic pain management program. Based upon 28 Texas Administrative Code §134.230 (1) and (5), 80% of $125.00 = $100.00. $100.00 X 145 hours = $14,500.00. The respondent paid $14,500.00. The requestor is due the difference between the MAR and amount paid of $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	6/28/2017 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812